The following documents indicate who can complete/change information on the documentation logs.

Color of Cell	Who Can Make Changes.
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed and can modify information after the log is signed.
	Provider NOTE--if information is changed after the form is signed, the change must be initialed.
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed. Only the provider can modify information after the log is signed. NOTE--if information is changed after the form is signed, the change must be initialed.

In addition--While it is acceptable to make changes as indicated above, all changes must be reasonable. For example--The Medicaid clerk has the ability to modify the student information on the documentation logs. This does not mean that the Medicaid clerk can change the student's name on the log from Jimmy Smith to Bobby Brown (unless the student's name has actually changed from Jimmy Smith to Bobby Brown). Another example--If a documentation log states "Math" and the IEP service states "Reading", the Medicaid clerk could not change the service on the documentation log to match the IEP as Math and Reading are two different services.

Case Management Assurance

Student Information

Name: Date of Birth (mm/dd/yy)

Diagnostic Code:

Provider Information

Provider Name: Name of School:

Supervisory Union Name :

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	IEP Hours Per Week (indicate if service is monthly)

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	
To:	

I assure that I provided the following number of hours of case management during this billing period.	_____Hours

Provider Signature: _____ **Date**: _____

Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: **Date of Birth (Mo/Day/Year):**

Diagnostic Code:

Provider Information

Provider Name: **Provider Title:**

Supervisory Union: **Name of School:**

IEP Service:

List the service being provided as it appears on the IEP. Add hours per week based on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes indicated in the IEP as a session. **If the minutes per session or group size are different then what is listed in the IEP, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month							Year	Month							Year
								Use this set of dates for a two-month billing period							
1	2	3	4	5	6	7		1	2	3	4	5	6	7	
8	9	10	11	12	13	14		8	9	10	11	12	13	14	
15	16	17	18	19	20	21		15	16	17	18	19	20	21	
22	23	24	25	26	27	28		22	23	24	25	26	27	28	
29	30	31						29	30	31					

Indicate the total number of hours of billable service provided during the billing period:	1:1 Service	Hours
	Small Group	Hours

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Personal Care Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Personal Care Hours Per Week: _____ **Does the student receive 1:1 services during their entire school week?** _____

Provider Information

Provider Name: **Provider Title:**

Supervisory Union: **Name of School:**

The student's current IEP requires full-time 1:1 personal care services.

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT**.

Month Year Month Year

Use this set of dates for a two-month billing period

1	2	3	4	5	6	7		1	2	3	4	5	6	7
8	9	10	11	12	13	14		8	9	10	11	12	13	14
15	16	17	18	19	20	21		15	16	17	18	19	20	21
22	23	24	25	26	27	28		22	23	24	25	26	27	28
29	30	31						29	30	31				

Total hours personal care was provided during the billing period _____ **hours**

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

1. ☐ **Assistance w/Eating**
2. ☐ **Assistance w/Toileting**
3. ☐ **Assistance w/Dressing**
4. ☐ **Assistance w/Hygiene**
5. ☐ **Behavior Management**
6. ☐ **Signing/Interpreting**
7. ☐ **Medication Admin.**
8. ☐ **Mobility/Safety**
9. ☐ **Assistive Devices**
10. ☐ **Other:** _____

_____

_____

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.
Not for use with Developmental and Assistive Therapy or Personal Care Services.

STUDENT INFORMATION	**PROVIDER INFORMATION**
Name: **Date of Birth:** **Diagnostic Code:**	**Provider Name:** **Provider Type:** **SU/School:**

Date mm/dd/yy	**Activity/Procedure/Service Brief Description**	**Small Group Or Individual**	**Minutes Per Session**

Group size must be six or less students for professional services or four or less students for paraprofessional services in order to be a Medicaid billable service. Use additional pages as necessary. **DO NOT USE DITTO MARKS, ARROWS, PENCIL or WHITE OUT**.

Actual hours of 1:1 services provided during the billing period	_____ **hours**
Actual hours of small group services provided during the billing period	_____ **hours**

Quarterly progress note to be completed on the back of this form.

Provider Signature: _____ **Date:** _____

Title: _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____